Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09300

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland, Md.
LENGTH OF STAY (in this place): 66
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 800 LaFayette Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland, Md.
STREET ADDRESS (If rural, give location): 800 La Fayette Ave.

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) H. (Last) Abe

4. DATE OF DEATH: (Month) Oct. (Day) 28, (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 6, 1883

9. AGE last birthday: 66 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Rigger

10b. KIND OF BUSINESS OR INDUSTRY: Celanese

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Philip Abe

14. MOTHER'S MAIDEN NAME: Annie Largent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-10-7639

17. INFORMANT AND ADDRESS: Wife 800 LaFayette Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardiac failure	2 days
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma Oesophagus	2 yrs.
	(c) Metastasis	

150
46a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949, to Oct 28, 1949, that I last saw the deceased alive on Oct 28, 1949, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE: John G. Dyer, M.D. (Degree or title) ADDRESS: 247 Virginia Ave DATE SIGNED: 10-29-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 10/31/49 — NAME OF CEMETERY OR CREMATORY: Abe Cem. Old Furnace Rd. — LOCATION (City, town, or county) (State): Mineral County, West Virginia

DATE REC'D BY LOCAL REG.: Oct. 29, 1949 — REGISTRAR'S SIGNATURE: Winter R. Tantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cumberland, Md.

RECEIVED
NOV 1 1949
BUREAU V. S.

Within corporate limits

Rees

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09301

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pa COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bedford Valley
STREET ADDRESS (If rural, give location) Route 3 Bedford Pa

3. NAME OF DECEASED (Type or Print) (First) Nathaniel (Middle) Thomas (Last) Athey

4. DATE OF DEATH (Month) October (Day) 20 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Nov 18 1885
9. AGE last birthday 63 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner (coal)
10b. KIND OF BUSINESS OR INDUSTRY Coal Mines
11. BIRTHPLACE (State or foreign country) Barton Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John C. Athey
14. MOTHER'S MAIDEN NAME Margaret Shatzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. 217-05-3177
17. INFORMANT AND ADDRESS Mrs Mildred Athey, Rt 3 Bedford Pa

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebrial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

331 Antecedent cause(s)

830 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 18, 1949, to Oct. 19, 1949, that I last saw the deceased alive on Oct. 19, 1949, and that death occurred at 12:15 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
David T Rees MD, 404 Allegany St Cumberland Md 10/20/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Oct 22, 1949
NAME OF CEMETERY OR CREMATORY Zion Memorial Park
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Oct. 22, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer - Cumberland Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 25 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09302

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (In this place): 35 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 300 Laing Ave.

3. NAME OF DECEASED (Type or Print): (First) Julia (Middle) May (Last) Bailey

4. DATE OF DEATH: (Month) Oct. (Day) 22 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Nov. 19-1871

9. AGE last birthday: 77 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Winchester, Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Johnston

14. MOTHER'S MAIDEN NAME: Lucy Custer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: --------

17. INFORMANT: Hospital Record.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intracranial hemorrhage — 5 hrs.

Antecedent cause(s) Diseases or conditinns, if any, giving rise to the above cause stating the underlying cause last
(b) Contusion of the brain (marked)
(c) hit by a truck.

852.5
170c

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing desth.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: Va. Ave. — (CITY OR TOWN): Cumberland — (COUNTY): Allegany — (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): Oct.22-49 A.m. 11
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Went to cross Va. Ave. and was hit by a truck.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: H.V.Deming M.D. — (Degree or title): H.V. Deming M.D. — ADDRESS: Cumberland Md. — DATE SIGNED: Oct.22-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Oct 25, 1949 | NAME OF CEMETERY OR CREMATORY: Hillcrest Cem. | LOCATION (City, town or county) (State): Cumberland, Allegany, Md.

DATE REC'D BY LOCAL REG.: Oct. 24, 1949 | REGISTRAR'S SIGNATURE: Winter R. Frantz M.D.

24. FUNERAL DIRECTOR: Louis Sleni Inc. — ADDRESS: Cumberland

RECEIVED
NOV 1 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09303

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural near Cumberland
LENGTH OF STAY (in this place) 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Bowman's Addition R.F.D 3

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural near Cumberland
STREET ADDRESS (If rural, give location) Bowman's Addition R.F.D.3

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Luther (Last) Beeler
4. DATE OF DEATH (Month) Oct. (Day) 26 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH Jan.20-1881
9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well driller
10b. KIND OF BUSINESS OR INDUSTRY drilling wells
11. BIRTHPLACE (State or foreign country) Pa. West Providence Township
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Samuel Beeler
14. MOTHER'S MAIDEN NAME Hannah Bowen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -
16. SOCIAL SECURITY NO. 216-22-6266
17. INFORMANT Birth certificate

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary embolus	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. H.V.Deming M.D. (Degree or title) ADDRESS Cumberland Md. DATE SIGNED Oct. 27-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct 30, 1949
NAME OF CEMETERY OR CREMATORY Cherry Lane Cemetery
LOCATION (City, town, or county) (Near) Everett, Penna. (State)
DATE REC'D BY LOCAL REG. Oct. 29, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR William H. Kight, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09304

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 4 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS 227 Welch Hill

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 227 Welch Hill

3. NAME OF DECEASED (Type or Print) (First) Fredrick (Middle) Richard (Last) Beeman
4. DATE OF DEATH (Month) Oct. (Day) 3 (Year) 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH Jan.31-1931
9. AGE last birthday 18 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY -----
11. BIRTHPLACE (State or foreign country) Lonaconing Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Beeman
14. MOTHER'S MAIDEN NAME Effie Beeman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mother) Effie Beeman Beeman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Lobar Pneumonia (lower left lobe)	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

490
108

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Oct.3-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct 7, 1949
NAME OF CEMETERY OR CREMATORY Samuel Hill
LOCATION (City, town, or county) (State) Moscow, Md

DATE REC'D BY LOCAL REG. 10-6-49
REGISTRAR'S SIGNATURE Mrs Nancy H. Roe
24. FUNERAL DIRECTOR Ellsworth S. Boal ADDRESS Westernport Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 11 1949
BUREAU V. S.

Within corporate limits
Rozum

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09305

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 10 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Blvd. Apts, Kelly-Springfield Blvd	STREET ADDRESS (If rural, give location) Blvd. Apts, Kelly Springfield Blvd.

3. NAME OF DECEASED (Type or Print) (First) Thomas (Middle) (Last) Berger				4. DATE OF DEATH (Month) October (Day) 7 (Year) 1949	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 19, 1879	9. AGE last birthday 70 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Engineer		10b. KIND OF BUSINESS OR INDUSTRY Steel Bridges	11. BIRTHPLACE (State or foreign country) Paris, Kentucky	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY NO. 376-14-7773	17. INFORMANT AND ADDRESS Mrs. Margaret Berger, Cumberland, Md.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Coronary disease

94a Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1, 1949, to 10/7, 1949, that I last saw the deceased alive on 10/6, 1949, and that death occurred at 4:30 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John K. Rozum	MD	Cumberland Md	10/8/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE October 10, 1949	NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. Oct. 8, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md.	ADDRESS

Rozum

Dr Rozum

RECEIVED
OCT 11 1949
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

09306

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 24hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Penna — COUNTY: Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fairhope
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Allie	B.	Blair	10	23	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	nov. 15, 1883	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Fairhope Pa.
12. CITIZEN OF WHAT COUNTRY? Usa

13. FATHER'S NAME: Franklin Emerick
14. MOTHER'S MAIDEN NAME: Mary Jane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Charles Blair

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Thrombosis	2 days
443 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Chronic Hypertensive Cardio Vascular Disease	10 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	—	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Oct 1, 1949, to Oct 23, 1949, that I last saw the deceased alive on 10/23, 1949 and that death occurred at 3.40 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John A Topper MD Hyndman Pa 10/24/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10/26/1949	Comps cemetery	Hyndman, Pa. RD#1

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 25, 1949	Walter R. Rank M.D.	Harvey H. Zeigler	Hyndman, Pa.

VS. A15

RECEIVED
NOV 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09307

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Marian; (Middle) Brown; (Last) Close

4. DATE OF DEATH: (Month) Oct. (Day) 9 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1-16-1877

9. AGE last birthday: 72 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Eckhart, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander Close

14. MOTHER'S MAIDEN NAME: Margaret Ferguson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Alexander Close, Frostburg, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) pulmonary edema	6 hours
450.0 Antecedent cause(s)	(b) heart failure	6 months
97 Diseases or conditions, if any, giving rise to the above cause statiog the underlying cause last	(c) arteriosclerosis	?

II. OTHER SIGNIFICANT CONDITIONS
Cooditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Mooth) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-9, 1949, to 10-9, 1949, that I last saw the deceased alive on 10-9, 1949, and that death occurred at 2:30 a. m., from the causes and on the date stated above.

SIGNATURE: A. Wolferman (Degree or title): M.D. ADDRESS: Frostburg Md. DATE SIGNED: 10-11-49.

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 10-11-1949 | NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery | LOCATION (City, town, or county) (State): Eckhart, Md.

DATE REC'D BY LOCAL REG.: 10-11-49 | REGISTRAR'S SIGNATURE: Mrs Nancy A Roe

24. FUNERAL DIRECTOR ADDRESS: J. R. Duret, Frostburg, Md.

RECEIVED
OCT 18 1949
BUREAU Y. S.

Within corporate limits Dr. Van Ormer

09308

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital	STREET ADDRESS (If rural, give location) 81 Bowery St.

3. NAME OF DECEASED (Type or Print)	(First) WALTER	(Middle) LEE	(Last) COOK	4. DATE OF DEATH	(Month) Oct.	(Day) 23	(Year) 1949
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 3-31-1895	9. AGE last birthday 54 yrs.	If under Months.	1 year Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) merchant	10b. KIND OF BUSINESS OR INDUSTRY grocery store	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME William H. Cook	14. MOTHER'S MAIDEN NAME Janet Morton						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) W. War 1	16. SOCIAL SECURITY NO. none	17. INFORMANT Francis Cook, Frostburg, Md.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion, acute, anterior, massive, with congestive heart failure and cardiac arrest.	10 days.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Diabetes mellitus, mild	unknown

260
61

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 13, 1949, to Oct. 23, 1949, that I last saw the deceased alive on Oct. 23, 1949 and that death occurred at 8:40 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. Alfred Van Ormer	M.D.	Cumberland, Md.	Oct. 24, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 10-25-1949	NAME OF CEMETERY OR CREMATORY Allegany Cemetery	LOCATION (City, town, or county) (State) Frostburg, Md.
DATE REC'D BY LOCAL REG. Oct. 25, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR J. R. Durst, Frostburg, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 1 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

09309

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 65 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 138 Bedford St.

3. NAME OF DECEASED (Type or Print): (First) Laura (Middle) B. (Last) Coron

4. DATE OF DEATH: (Month) Oct (Day) 8 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 3, 1884

9. AGE last birthday: 65 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John W. Chaney

14. MOTHER'S MAIDEN NAME: Maria Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: None.

17. INFORMANT AND ADDRESS: Nicholas J. Coron (husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: 1 hr. 10 min.

420.1 / 940 Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) General arteriosclerosis — 4 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 14, 1949, to Oct. 8, 1949, that I last saw the deceased alive on Oct. 7, 1949, and that death occurred at 11 OT a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Arthur F. Jones M.D. 110 S. Centre St. Oct. 8, 1949

23. BURIAL, CREMATION OR REMOVAL (Specify): Burial — DATE: Oct 10 '49 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cem. — LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG.: Oct. 10, 1949 — REGISTRAR'S SIGNATURE: Walter L. Hantz M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland

RECEIVED
OCT 18 1949
BUREAU T. S

Within corporate limits

Evidence for addition in #18 shown on:

FILM No. G 122 NOV 22 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09310

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 45 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 528 Greene St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 528 Greene St.

3. NAME OF DECEASED (Type or Print): Edgar (First) Howard (Middle) Edmondson (Last)

4. DATE OF DEATH: Oct (Month) 7 (Day) 1949 (Year)

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: About 1871
9. AGE last birthday: 78 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor - Retired
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Martin Edmondson
14. MOTHER'S MAIDEN NAME: Sydney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service): —
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Percy H Edmondson, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

434.1 Immediate cause (a) Myocardial failure, congestive heart failure [11/21/49 abc] — INTERVAL BETWEEN ONSET AND DEATH: 3 days

Antecedent cause(s)

93e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senility (over)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 5, 1949, to Oct. 7, 1949, that I last saw the deceased alive on Oct. 6, 1949, and that death occurred at 8 40 P. m., from the causes and on the date stated above.

SIGNATURE: Arthur F. Jones — (Degree or title): M.D. — ADDRESS: 110 S. Centre St. — DATE SIGNED: Oct. 8, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Oct 11 49 — NAME OF CEMETERY OR CREMATORY: Sumner Cem — LOCATION (City, town, or county): Cumberland — (State): Md

DATE REC'D BY LOCAL REG.: Oct. 8, 1949 — REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland Md

Jones

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

Mr. states man was probably in his middle nineteys. The age given on the certificate was obtained from his daughter.

11-21-49 - abc

RECEIVED
OCT 11 1949
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09311

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Route 1, Frostburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS National

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Route 1, Frostburg
STREET ADDRESS (If rural, give location) National

3. NAME OF DECEASED (Type or Print) (First) LAURA (Middle) (Last) EMERICK
4. DATE OF DEATH (Month) Oct. (Day) 15, (Year) 1949

5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 9-15-1869
9. AGE last birthday 80 yrs. If under 1 year Months, Days; If under 24 hrs. Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jacob Kennel
14. MOTHER'S MAIDEN NAME Susan Sturtz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Wilbur Emerick, Rt. 1, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Myocarditis	3 days
Antecedent cause(s) 442 131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-Vascular-Renal disease with hypertension	5 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/3/, 1949, to 10/15, 1949, that I last saw the deceased alive on 10/14, 1949, and that death occurred at 8:00 A m., from the causes and on the date stated above.

SIGNATURE N. E. Gattens (Degree or title) M.D. ADDRESS Frostburg Md. DATE SIGNED 10/15/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 10-17-49
NAME OF CEMETERY OR CREMATORY Allegany Cemetery
LOCATION (City, town, or county) Frostburg, Md. (State)

DATE REC'D BY LOCAL REG. 10-17-49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR J. R. Durst, Frostburg, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 21 1949
BUREAU, U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09312

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (In this place): 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miner's Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 228 Center St.

3. NAME OF DECEASED (Type or Print): (First) Melvina (Middle) (Last) Filer

4. DATE OF DEATH: (Month) Oct. (Day) 31 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 22-1916

9. AGE last birthday: 33 yrs.

If under 1 year: Months / Days

If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Frostburg Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Sires

14. MOTHER'S MAIDEN NAME: Lenor Hosken

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: Hospital records & husband

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Shock & acute cardiac failure due to — 2 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) pulmonary hemorrhage from punctured lung due to fractured ribs left side of chest.

(c) Fracture of left humerous & right femur.

8235
1700

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 5 months pregnant.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Highway

(CITY OR TOWN): Diehl (COUNTY): Sommerset (STATE): Pa.

TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 29/49 10.20 P. m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Failed to negotiate curve, foggy, rain & faulty brakes.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V. Deming M.D. H.V. Deming M.D. — ADDRESS: Cumberland Md. — DATE SIGNED: Nov. 1-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 11-3-1949 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 11-3-49 — REGISTRAR'S SIGNATURE: Mrs. Hawley N. Roe

24. FUNERAL DIRECTOR: Jacob Hafer. — ADDRESS: Frostburg, Md.

RECEIVED
NOV 5 1949
BUREAU V. S.

Within corporate limits

DR. A. JONES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09313

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. LENGTH OF STAY (in this place) 11 HRS.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.	STREET ADDRESS (If rural, give location) 312 MT. VIEW DRIVE

3. NAME OF DECEASED (Type or Print) (First) SALLY (Middle) (Last) GEARHART			4. DATE OF DEATH (Month) OCT. (Day) 26 (Year) 1949		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH Feb 25, 1878	9. AGE last birthday 71 yrs.	If under 1 year Months 8 Days 7 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME W. G. MELLINGER			14. MOTHER'S MAIDEN NAME ADELINE HAMILL		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Memorial Hospital		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Meningococcic meningitis	2 days
057.0 Antecedent cause(s)		
6 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 24, 1949, to Oct 26, 1949, that I last saw the deceased alive on Oct 24, 1949, and that death occurred at 12:05 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Charlotte B. Gardner		126 Columbia St. Cumberland	10/26/49 Md

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Oct 28 1949	NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	LOCATION (City, town, or county) Cumberland, Md. (State)
DATE REC'D BY LOCAL REG. Oct. 28, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR William H. Kight, Cumberland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 1 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09314

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural | LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.7.D.#1, Cash Valley Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Cumberland, Rural
STREET ADDRESS (If rural, give location) R.7.D.#1, Cash Valley Road

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Thomas (Last) Getson

4. DATE OF DEATH (Month) 10 (Day) 4 (Year) 1949

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 11/29/1886 | 9. AGE last birthday 63 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker | 10b. KIND OF BUSINESS OR INDUSTRY trucker | 11. BIRTHPLACE (State or foreign country) Cumberland Md. RD#11 | 12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Henry Getson | 14. MOTHER'S MAIDEN NAME Anna Petenbrink

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) Yes (If yes, give war or dates of service) W. War #1 | 16. SOCIAL SECURITY NO. 212-12-8916 | 17. INFORMANT Isabella Getson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Lumbar Vertebra 3 Down — Interval between onset and death: 2 yrs

180 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cancer Left kidney — 6 yrs Ago

520 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cancer Cachexia

19a. DATE OF OPERATION 1943 | 19b. MAJOR FINDINGS OF OPERATION Left Kidney Removed Cancer Found | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 3, 1949, to Aug 4, 1949, that I last saw the deceased alive on Aug 2, 1949, and that death occurred at 10 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) L. Dan G. Murray M.D. | ADDRESS Cumberland Md | DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 10/7/49 | NAME OF CEMETERY OR CREMATORY Greenmount | LOCATION (City, town, or county) (State) Cumberland Md.

DATE REC'D BY LOCAL REG. Oct. 7, 1949 | REGISTRAR'S SIGNATURE Winter R. Lantz, M.D. | 24. FUNERAL DIRECTOR Harvey. H. Zeigler | ADDRESS Hyndman, Pa

VS. A15

RECEIVED
OCT 11 1949
BUREAU P. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09315

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 938 Maryland Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 938 Maryland Ave.

3. NAME OF DECEASED (Type or Print): (First) Boyd (Middle) Casper (Last) Grove
4. DATE OF DEATH: (Month) Oct (Day) 7 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct 18 1888
9. AGE last birthday: 60 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Railway
11. BIRTHPLACE (State or foreign country): Shenandoah, W. Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thomas Grove
14. MOTHER'S MAIDEN NAME: Susan Duvall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY No.: 705-07-8718
17. INFORMANT AND ADDRESS: Elsie Bailey Grove, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — 10 min.

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive Cardio vascular disease — 6 months

(c)

430.1 93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug., 19 49, to Oct 7, 19 49, that I last saw the deceased alive on Oct 7, 19 49, and that death occurred at 2:10 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

George M Simon M.D. Cumberland Md Oct 8 1949

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct 11 '49	St Marys Burial Park	Near Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 8, 1949	Winter R. Frantz, M.D.	Long Stein Inc.	Cumberland

RECEIVED
OCT 11 1949
BUREAU F. S.

DR. ~~WILSON~~

Within corporate limits W F Wrois

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09325

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W. VA. COUNTY HAMPSHIRE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. — LENGTH OF STAY (in this place) 2 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PURGITSVILLE, W. VA.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print)	(First) CARRIE	(Middle)	(Last) HARTMAN	4. DATE OF DEATH	(Month) 10-17-49 (Day) (Year) 19
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JUNE 18, 1902	9. AGE last birthday 47 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) W. V.A	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM M. DAVY	14. MOTHER'S MAIDEN NAME EMMA S. MITCHELL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Subarachnoid hemorrhage	2½
330 Antecedent cause(s)	(b) Etiology undetermined	days
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Refused autopsy	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-15, 1949, to 10-17, 1949 that I last saw the deceased alive on 10-17, 1947, and that death occurred at 5:10 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. F. Williams		Cumberland	10/19/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 21, 1949	Ebenezer Cemetery	Near Romney, W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 19, 1949	Winter R. Frantz, M.D.	Thrush and Son, Romney, West Virginia	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 25 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

09316

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland, Md.
LENGTH OF STAY (In this place): 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Penna. — COUNTY: Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hyndman, Pa. RD#1 Rural
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Effie (Middle) Caroline (Last) Henderson

4. DATE OF DEATH: (Month) Oct. (Day) 30 (Year) 1949

5. SEX: Fe

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 3/ 16/ 1878

9. AGE last birthday: 71 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kellysburg, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Condron

14. MOTHER'S MAIDEN NAME: Caroline Wells

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: James L. Henderson, Hyndman, Pa. RD#1

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260 Immediate cause (a) Chronic Hypertensive Arteriosclerotic Heart Disease — Interval between onset and death: 10 yrs

61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Diabetes mellitus — 15 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 47, to Oct 30, 49, that I last saw the deceased alive on Oct. 30 1949, and that death occurred at 10.30 m., from the causes and on the date stated above.

SIGNATURE: John A Topper MD (Degree or title) — ADDRESS: Hyndman — DATE SIGNED: Pa 10/31/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 11/3/49 — NAME OF CEMETERY OR CREMATORY: Porter cemetery — LOCATION (City, town, or county) (State): Hyndman Pa. RD#1

DATE REC'D BY LOCAL REG.: Nov. 2, 1949 — REGISTRAR'S SIGNATURE: Wintes K. Wantz, M.D.

24. FUNERAL DIRECTOR: Harvey H. Zeigler — ADDRESS: Hyndman, Pa

VS. A15

NOV 6 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09317

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) CAROLINE (Middle) (Last) HIMMELWRIGHT

4. DATE OF DEATH: (Month) Oct. (Day) 7, (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 8-10-1873

9. AGE last birthday: 76 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Eckhart, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Sourbrine

14. MOTHER'S MAIDEN NAME: Amelia Schram

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Raymond Himmelwright, Mt. Savage, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemmorrhage.	3 days.
331 Antecedent cause(s)	(b) Vascular Hypertension	3 years.
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Generalized Arteriosclerosis.	3 years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1946, to Octobr, 1949, that I last saw the deceased alive on 10-6, 1949, and that death occurred at 2:45 A m., from the causes and on the date stated above.

SIGNATURE: William E. Moseley (Degree or title)

ADDRESS: Mt Savage Md.

DATE SIGNED: Octobr 7th 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Oct. 9 '49

NAME OF CEMETERY OR CREMATORY: St. George's Cemetery

LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG.: 10-9-49

REGISTRAR'S SIGNATURE: Veronica McDermott

24. FUNERAL DIRECTOR: J. R. Durst Frostburg, Md.

ADDRESS:

RECEIVED
OCT 12 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

09318

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (in this place): 2 Hrs & 20 Min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: W.Va. — COUNTY: Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Wiley Ford
STREET ADDRESS (If rural, give location): ✓

3. NAME OF DECEASED (Type or Print): (First) Morton (Middle) E. (Last) Houdershell
4. DATE OF DEATH: (Month) Oct. (Day) 27 (Year) 19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	Divorced	May 5-1878	71 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired) Trackman	W.Md.R.Ry	Morefield W.Va.	U.S.A.

13. FATHER'S NAME: James Houdershell
14. MOTHER'S MAIDEN NAME: Susan Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	705-10-8711	(Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Peritonitis due to a	about 4
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	ruptured gastric ulcer	days.
(c)		

540.1
117a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Oct.27-1949	Patient died before abdomen was opened.	Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☐, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.	Cumberland Md.	Oct.28-1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	oct, 30, 1949	Abe Cemetery	Mineral Co.	W.Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct 28, 1949	Winter R. Beatty, M.D.	John J. Hughes	Cumberland, Md.

RECEIVED
NOV 1 1949
BUREAU V. S.

Rees

09319

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flintstone
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Flintstone, Md.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Randolph (Last) House
4. DATE OF DEATH (Month) Oct (Day) 19 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH May 7, 1875
9. AGE last birthday 74 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY General Farming
11. BIRTHPLACE (State or foreign country) Flintstone, Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME James Allen House
14. MOTHER'S MAIDEN NAME Rebecca Browning
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS James House - Mt Savage Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Colon — INTERVAL BETWEEN ONSET AND DEATH: Unknown

153 Antecedent cause(s)

46e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 25, 1949, to Oct 17, 1949, that I last saw the deceased alive on Oct 17, 1949, and that death occurred at 11:55 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) D. J. Rees ADDRESS 404 Decatur St DATE SIGNED Cumberland Md 10/17/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Oct 22 1949
NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
LOCATION (City, town, or county) (State) Cumberland Md
DATE REC'D BY LOCAL REG. Oct. 22, 1949
REGISTRAR'S SIGNATURE Nina L. Bender
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland Md

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

RECEIVED
OCT 28 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09320

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 819 Columbia Ave.

3. NAME OF DECEASED (Type or Print): (First) Vincent (Middle) De Paul (Last) Ingram

4. DATE OF DEATH: (Month) Oct (Day) 6 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 16, 1896
9. AGE last birthday: 53 yrs. — If under Months. — I year Days — If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Nat Gypsum Co
11. BIRTHPLACE (State or foreign country): Davis W. Va
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Charles A. Ingram
14. MOTHER'S MAIDEN NAME: Catherine McMahon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W I
16. SOCIAL SECURITY NO.: 214-05-4348
17. INFORMANT AND ADDRESS: Angela Clay Ingram. Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Duodenal ulcer - pyloric obstruction

Antecedent cause(s)

541.1
117.8

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 10/16/49
19b. MAJOR FINDINGS OF OPERATION: Perforated duodenal ulcer
20. AUTOPSY? Yes ☐ No ☒

21. ~~ACCIDENT~~ SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ ~~Not While~~ At work ☐
~~HOW DID INJURY OCCUR?~~

22. I hereby certify that I attended the deceased from 9/16, 1949, to 10/7, 1949, that I last saw the deceased alive on 10/6, 1949 and that death occurred at 11:15 P.m., from the causes and on the date stated above.

SIGNATURE: John K Rozner MD (Degree or title) — ADDRESS: Cumberland Md — DATE SIGNED: 10/7/49.

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: October 10, 1949
NAME OF CEMETERY OR CREMATORY: St. Peter + Paul Cemetery
LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: Oct. 8, 1949
REGISTRAR'S SIGNATURE: Winter R. Frantz M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland

RECEIVED
OCT 11 1949
BUREAU V. S.

Within corporate limits DR. R. WILLIAMS

09321

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 17 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 506 GREENE STREET

3. NAME OF DECEASED (Type or Print)	(First) FLORA	(Middle) B	(Last) JOHNSON	4. DATE OF DEATH (Month) OCT. (Day) 30, (Year) 1949
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH MARCH 11, 97	9. AGE last birthday 52 ~~55~~ yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furrier	10b. KIND OF BUSINESS OR INDUSTRY Retail Fur Shop	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA, Romney	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE SHANK		14. MOTHER'S MAIDEN NAME Susan Peters		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. No	17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL-MEMORIAL AVENUE		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Toxemia from metastic carcinoma to lung — 3 mo

171 Antecedent cause(s) (b) Primary site cervix

48a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	(CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 8/15/49, 19....., to 10/30/49, 19....., that I last saw the deceased alive on 10/29/49, 19....., and that death occurred at 6 a m., from the causes and on the date stated above.

SIGNATURE R. J. Williams, M.D. (Degree or title) Med. ADDRESS Bldg Cumberland, Md DATE SIGNED 10/30/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Nov - 1, 1949	NAME OF CEMETERY OR CREMATORY 14th Crest Burial Park	LOCATION (City, town, or county) Cumberland, Md (State)
DATE REC'D BY LOCAL REG. Oct. 31, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR John J Hafer, Cumberland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 5 1949
BUREAU V. S.

09322

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 1

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) ~~Cumberland Md.~~ Oldtown
LENGTH OF STAY (in this place) 8 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 51 Cardinal Club Property

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) ~~Cumberland~~ Oldtown
STREET ADDRESS route 51 (If rural, give location) Cardinal Club Property

3. NAME OF DECEASED (Type or Print) (First) Emmett (Middle) Scott (Last) Judy

4. DATE OF DEATH (Month) Oct. (Day) 1 (Year) 1949

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Sept.14-1905

9. AGE last birthday 44 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm hand

10b. KIND OF BUSINESS OR INDUSTRY farm

11. BIRTHPLACE (State or foreign country) Grant Co. W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henson Judy

14. MOTHER'S MAIDEN NAME Mary M. Iman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-10-6556

17. INFORMANT Papers found in his room.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Intracranial hemorrhage due to a self — INTERVAL BETWEEN ONSET AND DEATH at once

976
164c

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) inflicted wound through frontal bone by a

(c) 32 caliber revolver.9-30-1949

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY home rural near (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Sept.30/49-1.30 about P.M.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Self inflicted bullet wound in fore-head

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Oct.1-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct 4 1949
NAME OF CEMETERY OR CREMATORY Sites Cemetery
LOCATION (City, town, or county) Pansy (State) W. Va.
DATE REC'D BY LOCAL REG. Oct. 3, 1949
REGISTRAR'S SIGNATURE Mrs. Sue C. Grinvan
24. FUNERAL DIRECTOR William H. Kight, ADDRESS Cumberland, Md.

Oct. 4/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 6 1949
BUREAU V. S.

Within corporate limits

DR. SIMONS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09323

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH- COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND | LENGTH OF STAY (in this place): 5 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: WEST VIRGINIA — COUNTY: Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: SPRINGFIELD
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) C. (Last) KIMBLE

4. DATE OF DEATH: (Month) OCTOBER (Day) 21 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: MARCH 7, 1908

9. AGE last birthday: 41 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: LEE MILLER

14. MOTHER'S MAIDEN NAME: DELINIA BAYS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Uremia	Unknown
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 442 131a	(b) Hypertensive cardio vascular renal	3 yrs
	(c) disease	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 15, 1949, to Oct 21, 1949, that I last saw the deceased alive on Oct 21, 1949, and that death occurred at 9:20 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

George M Simons M.D. Cumberland Md | 10/22/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: Oct. 24, 1949 | NAME OF CEMETERY OR CREMATORY: Davis Cemetery | LOCATION (City, town, or county) (State): Davis, W. Va.

DATE REC'D BY LOCAL REG.: Oct. 23, 1949 | REGISTRAR'S SIGNATURE: Wintes K. Frantz, M.D. | 24. FUNERAL DIRECTOR | ADDRESS: John J. Hafer Cumberland, Md.

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NOV 1 1949
BUREAU Y. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

09324

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 12 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 219 Carroll St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 219 Carroll St.

3. NAME OF DECEASED (Type or Print): (First) Alexander (Middle) Campbell (Last) King

4. DATE OF DEATH: (Month) Oct. (Day) 30 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: May-27-1900

9. AGE last birthday: 49 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Policeman

10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry.

11. BIRTHPLACE (State or foreign country): ~~Brooklyn~~ N.Y.City N.Y.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alexander King

14. MOTHER'S MAIDEN NAME: Margaret Connley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY No.: 113-01-6728

17. INFORMANT: Alfred King (brother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac failure due to	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary occlusion	at once
420.1 / 93d	(c) Chronic myocarditis	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.		Cumberland Md.	Oct.31-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 4,1949	Calvary Cem.	Queens, New York

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 1, 1949	Winter R. Frantz. M.D.	H. Wayne George	Cumberland, Md.

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NOV 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09326

Reg. Dist. No. 14

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ELLERSLIE — LENGTH OF STAY (in this place) 20 YEARS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ELLERSLIE
HOSPITAL OR INSTITUTION OR STREET ADDRESS KING FARM	STREET ADDRESS (If rural, give location) KING FARM

3. NAME OF DECEASED (Type or Print)	(First) IRENE	(Middle) MAY	(Last) KLAVUHN	4. DATE OF DEATH (Month) OCT. (Day) 21, (Year) 1949
5. SEX female	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH March 30, 1903	9. AGE last birthday 46 yrs. If under 1 year Months. Days. If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) HARDY CO. W. VA.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES W. MONGOLD		14. MOTHER'S MAIDEN NAME HATTIE B. HITE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS GEO. K. KLAVUHN ELLERSLIE, MD.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cancer Uterus — 4 yrs

174

Antecedent cause(s)

48b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to Oct 21, 1949, that I last saw the deceased alive on Oct 21, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John A Tapper — ADDRESS Hyndman Pa — DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE Oct. 23, 1949	NAME OF CEMETERY OR CREMATORY TRINTY LUTHERN CEMETERY	LOCATION (City, town, or county) (State) CUMBERLAND MD.
DATE REC'D BY LOCAL REG. Oct. 23, 1949	REGISTRAR'S SIGNATURE Winter R. Mantz M.D. J. Lloyd Helfer g.	24. FUNERAL DIRECTOR WILLIAM H. KIGHT	ADDRESS CUMBERLAND, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

09327

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 50 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 211 Averitt Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 211 Averitt Ave

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Lilly	Ward	Kraus		Oct	28	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	June 30 1877	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House	House Wife	Piedmont, Mineral Co, W. Va.	US

13. FATHER'S NAME: Godfrey Fazenbaker
14. MOTHER'S MAIDEN NAME: Georganna Butts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	No	None	Christian Kraus, 211 Averitt Ave, Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hypertensive Heart Disease with Failure	?
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic nephritis	
260 61	(c) Diabetes mellitus	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Jan., 19 4, to 28 Oct., 19 49, that I last saw the deceased alive on 27 Oct, 19 49, and that death occurred at 6 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. Alfred Von Ame		Cumberland, Md	

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct 30 1949	Zion Memorial Cemetery	Cumberland,	Maryland.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 29, 1949	Wm. K. Frantz, M.D.	William H. Kight, Cumberland, Md.	

VS-A15

Van Ormer

RECEIVED
NOV 1 1948
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

09328

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 639 Lincoln St.,

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
STREET ADDRESS (If rural, give location): 639 Lincoln St.,

3. NAME OF DECEASED (Type or Print): (First) Ella (Middle) Imler (Last) Kunkle

4. DATE OF DEATH: (Month) Oct. (Day) 4, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Dec. 10, 1876

9. AGE last birthday: 72 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hyndman, Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas Imler

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Wm. T. Turley 639 Lincoln St., Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Failure — [illegible]

Antecedent cause(s) (b) Arteriosclerosis — [illegible]

450.0

97

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 7, 1949 to Oct 7, 1949, that I last saw the deceased alive on Oct 7, 1949, and that death occurred at 3:00 a.m., from the causes and on the date stated above.

SIGNATURE: [illegible] (Degree or title) — ADDRESS: 40 Decatur — DATE SIGNED: 10-6-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Oct. 7, 1949 — NAME OF CEMETERY OR CREMATORY: Rose Hill — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 7, 1949 — REGISTRAR'S SIGNATURE: Winter L. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.

RECEIVED
OCT 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09329

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport. — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Maryland Avenue.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport,
STREET ADDRESS (If rural, give location) Maryland Avenue.

3. NAME OF DECEASED (Type or Print): (First) Cecelia (Middle) E. (Last) Laffey.

4. DATE OF DEATH: (Month) Oct. (Day) 28 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 15, 1880.

9. AGE last birthday: 68 yrs. — If under 1 year: Months 10 Days 13 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Lonaconing, Md. [illegible] Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Michael Morgan.

14. MOTHER'S MAIDEN NAME: Mary E. Lannon.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: James P. Laffey.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of uterus — Interval between onset and death: 4 years

174 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 480 (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to Oct 27, 1949, that I last saw the deceased alive on Oct 27, 1949, and that death occurred at 11:10 P m., from the causes and on the date stated above:

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

James H Wharton Jr MD — Piedmont W. Va — 10-29-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct. 31, 1949 — NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery — LOCATION (City, town, or county) (State): Westernport, Alle. Md.

DATE REC'D BY LOCAL REG. Oct. 30/49. — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR — ADDRESS: W. Harold Fredlock — Piedmont, W. Va.

VS. A15

RECEIVED
OCT 29 1949
BUREAU V. S.

09330

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH COUNTY: Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
LENGTH OF STAY (in this place): 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Calla Hill

2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
STREET ADDRESS (If rural, give location): Calla Hill

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Wayne Elmer Lashley

4. DATE OF DEATH (Month) (Day) (Year): 10 21 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 2 1886
9. AGE last birthday: 63 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY: Kelly Tire Co.
11. BIRTHPLACE (State or foreign country): Bedford Valley, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Lashley
14. MOTHER'S MAIDEN NAME: Lorcas Robinette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-03-1111
17. INFORMANT AND ADDRESS: Mrs Wayne Lashley Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic Pulmonary Tuberculosis	5 years
Antecedent cause(s)	(b) Hemorrhage of lungs	3 days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

002
13b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1944, to Oct 21, 1949, that I last saw the deceased alive on Oct 20, 1949, and that death occurred at 4.30 a.m., from the causes and on the date stated above.

SIGNATURE: Alan G. Murray (Degree or title) ADDRESS: Cumberland Md. DATE SIGNED: Oct 22 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 10-23-1949
NAME OF CEMETERY OR CREMATORY: Methodist Cemetery
LOCATION (City, town, or county) (State): Mt Savage, Md.

DATE REC'D BY LOCAL REG.: 10-23-49
REGISTRAR'S SIGNATURE: Veronica McDermott
24. FUNERAL DIRECTOR: Jacob Hafer ADDRESS: Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 28 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

09331

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (In this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: La Vale
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Timothy (Middle) Andrew (Last) Law

4. DATE OF DEATH: (Month) Oct. (Day) 28 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: July-10-1886

9. AGE last birthday: 63 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired) Locomotive Engineer

10b. KIND OF BUSINESS OR INDUSTRY: W.Md.R.Ry.

11. BIRTHPLACE (State or foreign country): Pittsburg Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Julius Law

14. MOTHER'S MAIDEN NAME: Anna Day

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-10-7072

17. INFORMANT: wife) Virginia Long Law.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac failure due pulmonary	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (908.5 186a)	(b) embolism(marked) due to a deep laceration of right knee, also had a skull fracture &	
	(c) contusion of brain, right frontal lobe.	3 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fell in a hole while walking along highway.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes [*] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [*] OR CONTRIBUTING [ ] CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): route 40 — (CITY OR TOWN): La.Vale — (COUNTY): Allegany — (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): about 9-15 Oct.25/49 P/m.

INJURY OCCURRED While at work [ ] Not while at work [*]

HOW DID INJURY OCCUR? Construction of Hgw. Walking, foggy & fell in a hole.

22. *I certify that I took charge of the remains described above, held an Autopsy [*], Inspection [*], Inquiry [*] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [*], suicide [ ], homicide [ ], undetermined [ ].*

SIGNATURE (Degree or title): H.V.Deming M.D — ADDRESS: H. V. Deming M.D. Cumberland Md. — DATE SIGNED: Oct.29-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct 31 1949 — NAME OF CEMETERY OR CREMATORY: Rose Hill Cem. — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Oct. 29. 1949 — REGISTRAR'S SIGNATURE: Winter K. Kantz. M.D.

24. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Cumberland, Md.

RECEIVED
NOV 1 1949
BUREAU P. S.

Within corporate limits

20

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09332

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
HOSPITAL OR INSTITUTION OR STREET ADDRESS 805 Braddock Rd.	STREET ADDRESS (If rural, give location) 805 Braddock Rd.

3. NAME OF DECEASED (Type or Print)	(First) LEO	(Middle) HENRY	(Last) LEY	4. DATE OF DEATH	(Month) Oct. (Day) 20, (Year) 1949
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 29, 1888	9. AGE last birthday 61 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Manager	10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.	11. BIRTHPLACE (State or foreign country) St. Marys' Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME George Ley	14. MOTHER'S MAIDEN NAME Catherine Rohner				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service)	16. SOCIAL SECURITY No. 214-07-0837	17. INFORMANT AND ADDRESS Mrs. Irene Ley 805 Braddock Rd. Cumb.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinomatosis Generalized	
154 Antecedent cause(s)		
46d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Adeno. Carcinoma. Recto-Sigmoid-	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 25 June 49.	19b. MAJOR FINDINGS OF OPERATION Primary Ca. Recto Sigmoid - Generalized Metastases	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 25 June, 1949, to 20 Oct, 1949, that I last saw the deceased alive on 20 Oct, 1949, and that death occurred at 9 10 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Fuller B. Whitworth	M.D.	Cumberland	Md. 21 Oct 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Oct. 24, 1949	NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul	LOCATION (City, town, or county) (State) Cumberland, Md.
DATE REC'D BY LOCAL REG. Oct. 22, 1949	REGISTRAR'S SIGNATURE Winter R. Lantz. M.D.	24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.	ADDRESS

RECEIVED
OCT. 25 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09333

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 419 Washington Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CHARLES	ANDREW	LILLER	Oct.	14	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	Single	Oct. 13, 1949	yrs.		1		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): MARYLAND Cumberland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES BURTIS LILLER
14. MOTHER'S MAIDEN NAME: ELISABETH ANN HOLMES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Charles B. Liller

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Spina bifida - myelomeningocele	32 hr.
Antecedent cause(s)	(b) Encephalocele	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Pulmonary edema	

752
151b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 13 1949 to Oct. 14 1949, that I last saw the deceased alive on Oct. 14, 1949, and that death occurred at 5:15 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. Royce Hodges - Cumberland, Md. 10/15/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	Oct. 16, 1949	HILL CREST CEMETERY	CUMBERLAND MARYLAND

DATE REC'D BY LOCAL REG.: Oct. 16, 1949
REGISTRAR'S SIGNATURE: Wirates L. Hantz, M.D.
24. FUNERAL DIRECTOR: John C. Wolford
ADDRESS

RECEIVED
OCT 25 1949
BUREAU V. M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09334

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport Md.; LENGTH OF STAY (in this place) 60 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 108 Railroad St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural, give location) 108 Railroad St.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) William (Last) Linkswiler

4. DATE OF DEATH: (Month) October (Day) 30 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Feb 4, 1889

9. AGE last birthday: 60 yrs. If under 1 year: Months. If under 24 hrs.: Days, Hours, Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): Westernport, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: David Linkswiler

14. MOTHER'S MAIDEN NAME: Delilah Buckalew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 236-03-2970

17. INFORMANT: Harry Hackett

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocarditis	1 yr
523.1 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Miners Asthma	5 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Secondary Anemia — 6 mos

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: INJURY OCCURRED While at Work ☐ Not While At work ☐: HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1944, to Oct 30, 1949, that I last saw the deceased alive on Oct 30, 1949, and that death occurred at 6a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): J.E. Berry M.D. ADDRESS: Piedmont W Va DATE SIGNED: Nov 1-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE: Nov 2 1949; NAME OF CEMETERY OR CREMATORY: Philos Cemetery; LOCATION (City, town, or county) (State): Westernport, Maryland

DATE RECD BY LOCAL REG.: Nov. 3 1949; REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR ADDRESS: Ellsworth S. Boal Westernport, Md.

VS. A15

RECEIVED
NOV 3 1949
BUCKLAU V. B.

Within corporate limits DR. FAW

09335

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH· COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE MARYLAND COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 2hrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LONACONING
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital	STREET ADDRESS (If rural, give location) RAILROAD STREET

3. NAME OF DECEASED (Type or Print) (First) Elizabeth (Middle) (Last) MAJOR			4. DATE OF DEATH (Month) October (Day) 17 (Year) 1949	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH March 29, 1870	9. AGE last birthday 79 yrs. If under Months. 1 year Days If under Hours 24 hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Goddard Doerr			14. MOTHER'S MAIDEN NAME Unknown.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. None		17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hernia, umbilical, strangulated intestine, obstruction	2 days.
561.2 Antecedent cause(s)	(b) Myocardial insufficiency with progressive heart failure	unknown
122a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) myocardial failure, acute, & auricular fibrillation	12 hours

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Oct 17, 1949	19b. MAJOR FINDINGS OF OPERATION Strangulated umbilical hernia, gangrenous intestine	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) No	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) No	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 17, 1949, to Oct 17, 1949, that I last saw the deceased alive on Oct 17, 1949, and that death occurred at 11:47P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wylie M Faw Jr		Cumberland Md.	Oct. 18. 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Oct. 20, 1949	NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	LOCATION (City, town, or county) (State) Lonaconing, Maryland
DATE REC'D BY LOCAL REG. Oct. 18, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz. M.D.	24. FUNERAL DIRECTOR M. Eichhorn,	ADDRESS " "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 25 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09336

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 7 1/2 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Flintstone
STREET ADDRESS (If rural, give location): R*F*D*#0*Route 40

3. NAME OF DECEASED (Type or Print): (First) Gertrude (Middle) V. (Last) Mauzy
4. DATE OF DEATH: (Month) Oct. (Day) 7 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 13-1885
9. AGE last birthday: 64 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Riverton W.Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Isaac Mallow
14. MOTHER'S MAIDEN NAME: Mollie Dove

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: ------
17. INFORMANT: daughter) A.Mauzy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Shock due to a retoperitoneal hemorrhage	8 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) from a fractured pelvis also had a compound comminuted fracture of left leg above ankle and a	
	(c) compound fracture of right leg above ankle.	

812.5
170 c

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes [*] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [*] OR CONTRIBUTING [*] CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.): Route 40 highway
(CITY OR TOWN): Flintstone Md.
(COUNTY): Allegany
(STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 6/49-8.30 P. m.
INJURY OCCURRED While at work [ ] Not while at work [*]
HOW DID INJURY OCCUR?: Hit by an automobile

22. *I certify that I took charge of the remains described above, held an Autopsy [*], Inspection [*], Inquiry [*] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [*], suicide [ ], homicide [ ], undetermined [ ].*

SIGNATURE (Degree or title) ADDRESS — DATE SIGNED

H.V.Deming M.D. H.V.Deming M.D. Cumberland Md. Oct. 7-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: October 9 1949
NAME OF CEMETERY OR CREMATORY: I O O F Cemetery
LOCATION (City, town, or county) (State): near Flintstone Md

DATE REC'D BY LOCAL REG.: Oct. 8, 1949
REGISTRAR'S SIGNATURE: Walter L. Mantz. M.D.
24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer Cumberland Md

VS. A15A

RECEIVED
OCT 11 1949
BUREAU V. S.

Within corporate limits

Arthur Jones

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09337

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M (The correct age is especially important. Physicians: please write the causes of death clearly and legibly.)

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

I

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural near Cumberland
STREET ADDRESS (If rural, give location): Rt 2 Winfield Road.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Wilma	Jenifer	McCabe	Oct	17	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	white	Sing	Sept 6, 1949	yrs.	1	11		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Clarksburg W. Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wm Jennings McCabe
14. MOTHER'S MAIDEN NAME: Juanita Metzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Wm J. McCabe - Rt 2 Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Gastro-enteritis	6 wks.
571.0 Antecedent cause(s)		
119a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Oct. 15, 1949, to Oct. 17, 1949, that I last saw the deceased alive on Oct. 16, 1949, and that death occurred at 1:00 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	Oct. 19, 1949

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct 19, 1949	Ryan Cemetery	Town Hill, Allegany Co Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 19, 1949	W. R. Kantz, M.D.	John J. Hafer	Cumberland Md

RECEIVED
OCT 25 1949
BUREAU V. S.

Within corporate limits

DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09338

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD. | LENGTH OF STAY (in this place): 20
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give locatinn): 518 AVONDALE AVE.

3. NAME OF DECEASED (Type nr Print): (First) THOMAS (Middle) R. (Last) MC DONALD

4. DATE OF DEATH: (Month) 10- (Day) 20- (Year) 49 19

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 8-13-1903

9. AGE last birthday: 46 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind nf wnrk done during most nf working life, even if retired): Del Teller

10b. KIND OF BUSINESS OR INDUSTRY: Defence Corp of Am.

11. BIRTHPLACE (State nr fnreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: GEORGE MC DONALD

14. MOTHER'S MAIDEN NAME: JOHANNA GLEASON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, nn, nr unknown) | (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-07-4901

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL, MEMORIAL AVE.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocardial Degeneration — Interval Between Onset and Death: Due to 49

420.1 Antecedent cause(s) — Diseases nr conditions, if any, giving rise to the above cause stating the underlying cause last 93d

(b) Coronary Thrombosis — Contrib to 49

(c) Coronary Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but nnt related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ Nn ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Hnme, farm, factory, street, nffice bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Wnrk ☐ Nnt While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-22-, 19 49, to 10-20-49, 19, that I last saw the deceased alive on 10-20-, 19 49, and that death occurred at 12:45 P. m., from the causes and on the date stated above.

SIGNATURE: W. F. Williams (Degree or title) | ADDRESS: Cumberland | DATE SIGNED: 10-22-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Oct 24 1949 | NAME OF CEMETERY OR CREMATORY: St. Marys Cem. | LOCATION (City, town, nr county) (State): Cumberland, md

DATE REC'D BY LOCAL REG.: Oct. 22, 1949 | REGISTRAR'S SIGNATURE: Miles K. Frantz, M.D. | **24. FUNERAL DIRECTOR** | ADDRESS: James J. Scarpelli Cumberland Md

RECEIVED
OCT 25 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

09339

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 30 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 47 N. Mechanic St.

3. NAME OF DECEASED (Type or Print) (First) Brande (Middle) Marion (Last) McFarland
4. DATE OF DEATH (Month) Oct (Day) 11 (Year) 1949
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Dec 2 1882
9. AGE last birthday: 66 yrs. — If under 24 hrs. Months — 1 year Days — If under 24 hrs. Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Lonaconing Md
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: John Darnley
14. MOTHER'S MAIDEN NAME: Catherine Mackay
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: John Raymond McFarland, City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

? Immediate cause (a) Cirrhosis of the liver (approx) — 1 year

450.0 Antecedent cause(s)

124.6 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Malnutrition — 2 years

(c) Arteriosclerosis, generalized, severe — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: No
19b. MAJOR FINDINGS OF OPERATION: No
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): No
TIME OF INJURY (Month) (Day) (Year) (Hour): No m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? No

22. I hereby certify that I attended the deceased from Sep 27, 1949, to Oct 11, 1949, that I last saw the deceased alive on Oct 10, 1949, and that death occurred at 6:20 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Lavelle A. Weisneder MDS — ADDRESS: 122 Bedford St Cumberland — DATE SIGNED: Oct 12 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Oct. 13, 1949 — NAME OF CEMETERY OR CREMATORY: Oak Hill Cem. — LOCATION (City, town, or county) (State): Lonaconing Md.

DATE REC'D BY LOCAL REG.: Oct. 13, 1949 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland

RECEIVED
OCT 18 1949
BUREAU V. S.

WILLIAM R. RAWSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09340

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: ALLEGANY
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 40 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 504 HOLLAND ST.

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) ANN (Last) MILLER

4. DATE OF DEATH: (Month) OCT. (Day) 29 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE

8. DATE OF BIRTH: SEPT. 19, 1949

9. AGE last birthday: yrs. If under 1 year: Months 1, Days 10, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: CHARLES H. MILLER

14. MOTHER'S MAIDEN NAME: MARGARET HOGAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT AND ADDRESS: Charles H. Miller, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

751 Immediate cause (a) Hydrocephalus, Spina Bifida, Meningomyelocoel — Interval between onset and death: 40 days

Antecedent cause(s)

759a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 19, 1949, to Oct 29 1949, that I last saw the deceased alive on 28 Oct, 1949, and that death occurred at 1:20 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Leland D Rawson M D — ADDRESS: 63 Greene St., Cumberland Md — DATE SIGNED: 29 Oct 49

23. BURIAL, CREMATION or REMOVAL (Specify): Burial — DATE: Oct. 31, 1949 — NAME OF CEMETERY OR CREMATORY: St Peter & Paul's Cem — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Oct. 29, 1949 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: Louis Stein, Inc, Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 1 1949
BUREAU Y. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09341

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND; LENGTH OF STAY (in this place) 6.1/2 hrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Garrett; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oakland; STREET ADDRESS (If rural, give location) Box 262

3. NAME OF DECEASED (Type or Print): (First) Albert (Middle) (Last) Naser

4. DATE OF DEATH: (Month) Oct. (Day) 22 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): divorced

8. DATE OF BIRTH: Nov. 25-1885

9. AGE last birthday: 63 yrs. If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet metal worker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Pittsburg Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Naser

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Memorial Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

578
123

Immediate cause (a) Peritonitis — Interval Between Onset and Death: about 3

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) due to a ruptured diverticulum — days.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V.Deming M.D. Cumberland Md. Oct. 23-1949

23. BURIAL, CREMATION REMOVAL (Specify): Removal

DATE THEREOF: Oct 26, 1949

NAME OF CEMETERY OR CREMATORY: Pittsburgh Cemetery

LOCATION (City, town, or county) (State): Pittsburgh Pa.

DATE REC'D BY LOCAL REG.: Oct. 23. 1949

REGISTRAR'S SIGNATURE: Walter R. Kantz. M.D.

24. FUNERAL DIRECTOR: Kenneth L. Hite, ADDRESS: Cumberland, Md.

VS. A15A

RECEIVED
NOV 1 1949
BUREAU V. S.

Within corporate limits: Dick Wms

09342

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bowmans Addition
STREET ADDRESS (If rural, give location): Rt 3 Cumberland Md.

3. NAME OF DECEASED (Type or Print): (First) Melissa (Middle) Victoria (Last) Perrin
4. DATE OF DEATH: (Month) Oct (Day) 9 (Year) 1949
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Jan 18, 1872
9. AGE last birthday: 77 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Isaac Collins
14. MOTHER'S MAIDEN NAME: Nancy Lashley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: McClelland C. Perrin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 1 hr.

420.1 Antecedent cause(s) (b) Arteriosclerosis

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Mid Thigh Amputation left leg

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9/17/49
19b. MAJOR FINDINGS OF OPERATION: Gangrenous left leg
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) Cumberland (COUNTY) Alleg (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/1/49, 19....., to 10/9/49, 19....., that I last saw the deceased alive on 10/9/49, 19....., and that death occurred at 6:55 P.m., from the causes and on the date stated above.

SIGNATURE: B. Williams (Degree or title) MD — ADDRESS: Cumberland Md — DATE SIGNED: 10/10/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 10/12/49 — NAME OF CEMETERY OR CREMATORY: Mt Zion Christian Cemetery — LOCATION (City, town, or county): Chaneysville (State): Pa
DATE REC'D BY LOCAL REG.: Oct. 10, 1949 — REGISTRAR'S SIGNATURE: Winter K. Frantz M.D.
24. FUNERAL DIRECTOR: John J Hafer — ADDRESS: Cumberland Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
OCT 15 1949
BUREAU V. S.

Outside of City Limits

09343

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Cumberland; LENGTH OF STAY (in this place) 2 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Cash Valley Rd. R.F.D.#1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cash Valley Cumberland R.F.D.1; STREET ADDRESS (If rural, give location) near Cumberland, Rural

3. NAME OF DECEASED (Type or Print): (First) Christian (Middle) — (Last) Pfeiffer

4. DATE OF DEATH: (Month) October (Day) 20 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct 27 1866

9. AGE last birthday: 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Glassblower (retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Frederick Pfeiffer - Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive heart failure — Interval Between Onset and Death: 6 months

420.0 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerotic heart disease — 2 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-3-, 1948, to 10-20-, 1949, that I last saw the deceased alive on 10-15-, 1949, and that death occurred at 6 A m., from the causes and on the date stated above.

SIGNATURE: L. Weiss (Degree or title) MD ADDRESS 59 Green St. DATE SIGNED 10-20-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Oct 22 49 — NAME OF CEMETERY OR CREMATORY: St Peter & Pauls Cem — LOCATION (City, town or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Oct. 21, 1949 — REGISTRAR'S SIGNATURE: Walter K. Frantz, M.D. — 24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland Md

LB.

Stein

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09344

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (In this place) 7 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barkeville - P.O. Keyser, W. Va. R.D.1; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Rosa (Middle) (Last) Porter

4. DATE OF DEATH: (Month) October (Day) 9 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 15 1884

9. AGE last birthday: 64 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John William Lowery

14. MOTHER'S MAIDEN NAME: Anna S. Cox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Louis E. Lowery

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chr Nephritis	1 year
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chr Myocarditis - Diabetes	2 yrs 4 yrs
260 61	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: no

19b. MAJOR FINDINGS OF OPERATION: no

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945, 19..., to Oct 9th, 1949, that I last saw the deceased alive on Oct 9th, 1949, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

SIGNATURE: W W McClane (Degree or title) M.D. ADDRESS: Frostburg Md DATE SIGNED: 10-10-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: Oct. 12, 1949; NAME OF CEMETERY OR CREMATORY: Cooks Mills; LOCATION (City, town, or county) (State): Keyser, R.N. W. Va.

DATE REC'D BY LOCAL REG.: 10-12-49; REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: Harvey L. Leigler; ADDRESS: Keyser, W. Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 18 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09345

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 525 Maryland Ave.,

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
STREET ADDRESS (If rural, give location): 525 Maryland Ave.,

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) LEE (Last) POWNALL

4. DATE OF DEATH: (Month) Oct. (Day) 10, (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 22, 1890
9. AGE last birthday: 59 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Yard foreman
10b. KIND OF BUSINESS OR INDUSTRY: B.&O. Railway
11. BIRTHPLACE (State or foreign country): Springfield, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John D. Pownall
14. MOTHER'S MAIDEN NAME: Ella L. Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY No.: 705-07-9540
17. INFORMANT AND ADDRESS: Mrs. Marie Pownall 525 Md. Ave. Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Acute coronary occlusion	1/2 hour
420.0 Antecedent cause(s)			
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	chronic arteriosclerotic heart disease	1/2 year
	(c)		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-3-, 1948, to 10-10-, 1949, that I last saw the deceased alive on 10-10-, 1949, and that death occurred at 10 30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): L Perrins MD — ADDRESS: 59 Greene St. — DATE SIGNED: 10-11-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: Oct. 12, 1949
NAME OF CEMETERY OR CREMATORY: Hill Crest
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Oct. 12, 1949
REGISTRAR'S SIGNATURE: Winter R. Trantz, M.D.
24. FUNERAL DIRECTOR — ADDRESS: H. Wayne George Cumberland, Md.

RECEIVED
OCT 18 1949
BUREAU V. S.

Within corporate limits DR. HAWKINS

09346

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD. — LENGTH OF STAY (in this place): 12 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 6 VIRGINIA AVE.

3. NAME OF DECEASED (Type or Print) (First): THOMAS (Middle): W. (Last): PUGH

4. DATE OF DEATH (Month) (Day) (Year): OCT. 28 1949

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: NOV. 21 1870
9. AGE last birthday: 78 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MAHLON, PUGH
14. MOTHER'S MAIDEN NAME: REBECCA NIXON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiorenal Collapse

194 Antecedent cause(s) (b) Following Removal lag, R Lobe Hypoid

55c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) probably malignant.

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Thick Cap which was not removed.

19a. DATE OF OPERATION: 10/26/49
19b. MAJOR FINDINGS OF OPERATION: Cumberland Allegany Md.
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 18, 1949, to Oct. 28, 1949, that I last saw the deceased alive on 10/28, 1949, and that death occurred at 11:07a m., from the causes and on the date stated above.

SIGNATURE (Degree or title): A. H. Hawkins — ADDRESS: Cumberland Md. — DATE SIGNED: 10/28/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Oct 30, 1949 — NAME OF CEMETERY OR CREMATORY: Mt Union Cem. — LOCATION (City, town, or county) (State): Near Augusta, W. Va.

DATE REC'D BY LOCAL REG.: Oct. 28, 1949 — REGISTRAR'S SIGNATURE: Winter R. Frantz M.D. — 24. FUNERAL DIRECTOR: W H McKee Augusta W.Va. — ADDRESS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
OCT 1 1949
BUREAU V. S.

Within corporate limits

09347

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 26 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 26 Bedford St.

3. NAME OF DECEASED (Type or Print) (First) Norman (Middle) Claude (Last) Redman

4. DATE OF DEATH (Month) Oct (Day) 14 (Year) 1949

5. SEX Male

6. COLOR OR RACE Black

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Jan 6, 1888

9. AGE last birthday 61 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor

10b. KIND OF BUSINESS OR INDUSTRY Fruit Mkt.

11. BIRTHPLACE (State or foreign country) Pattersons Creek W. Va

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Charles Redman

14. MOTHER'S MAIDEN NAME Susan Hamilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No. 220-10-2439

17. INFORMANT AND ADDRESS Mrs John Cooper - 26 Bedford St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Generalized arteriosclerosis, Hypertension, 3 months

447

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

97

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15, 1949, to Oct. 14, 1949, that I last saw the deceased alive on Oct. 13, 1949, and that death occurred at 2:00 A.M. m., from the causes and on the date stated above.

SIGNATURE B. M. Schindler (Degree or title) M.D. ADDRESS 41 Everett Cumberland Md DATE SIGNED Oct 16, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Oct 16, 1949

NAME OF CEMETERY OR CREMATORY Thorn Rose Cemetery

LOCATION (City, town, or county) Keyser (State) W. Va.

DATE REC'D BY LOCAL REG. Oct. 16, 1949

REGISTRAR'S SIGNATURE Winter R. Frantz M.D.

24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 25 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09348

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Barrellsville
STREET ADDRESS (If rural, give location): Rt. 1, Hyndman, Pa.

3. NAME OF DECEASED (Type or Print): (First) Genettie (Middle) Victoria (Last) Reed

4. DATE OF DEATH: (Month) October (Day) 29 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 6, 1899

9. AGE last birthday: 50 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Midland, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Balford Kelley

14. MOTHER'S MAIDEN NAME: Martha Boyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs. Geraldine Bridges, Barrellsville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Peritonitis, chemical — Interval between onset and death: 11 days

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
541.1
117b
(b): Ruptured duodenal ulcer
(c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.: none

19a. DATE OF OPERATION: Oct. 27, 1949

19b. MAJOR FINDINGS OF OPERATION: Ruptured duodenal ulcer. Peritonitis

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): / — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: — INJURY OCCURRED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 25 49, to Oct. 29 49, that I last saw the deceased alive on Oct. 29 49, and that death occurred at 2.50 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
James P. Hartman M.D. — 200 Decatur St. Cumberland Md. — Nov. 1, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Nov 1, 1949 — NAME OF CEMETERY OR CREMATORY: Methodist Cemetery — LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG.: Nov. 1, 1949 — REGISTRAR'S SIGNATURE: Walter K. Hauch, M.D.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hofer, Cumberland, Md.

RECEIVED
NOV 5 1949
BUREAU F. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09349

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 8 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 219 Maple St.

3. NAME OF DECEASED (Type or Print): (First) Steven (Middle) Michael (Last) Rice

4. DATE OF DEATH: (Month) Oct. (Day) 16 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Sept.26-1949

9. AGE last birthday: 0 yrs. — If under 1 year: Months 3 / Days / If under 24 hrs.: Hours / Min. — weeks

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -------

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Harry R. Rinehartt

14. MOTHER'S MAIDEN NAME: Hilda C.Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: -------

17. INFORMANT: Mother & Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Lobar pneumonia	about 2
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Acute dilatation of the heart.	days
	(c) Collapse of left lung.	

7620
108

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.		Cumberland Md.	Oct.16 1949

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Oct 17 1949	Greenmount Cem	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 17, 1949	Winter R. Frantz, M.D.	Louis Stein Inc.	Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

Within corporate limits DR. ENFIELD

09350

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. — LENGTH OF STAY (in this place) 5 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location) 24 N. WAVERLEY TERRACE

3. NAME OF DECEASED (Type or Print)	(First) CARRIE	(Middle) A	(Last) RUSSELL	4. DATE OF DEATH	(Month) 10-	(Day) 8-	(Year) 49
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH JULY 25, 1872	9. AGE last birthday 77 yrs.	If under 1 year Months.	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) PA.	12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME MERRICK STONER	14. MOTHER'S MAIDEN NAME MARY LYNN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac Failure

154 Antecedent cause(s) (b) Abdominal Perineal Resection

46d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Carcinoma of rectum & liver.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Oct-6-49	19b. MAJOR FINDINGS OF OPERATION Carcinoma of rectum	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1949, to Oct 8, 1949, that I last saw the deceased alive on Oct 9, 1949, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE S. E. Enfield (Degree or title) ADDRESS Cumberland DATE SIGNED Oct 9, 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Oct. 10, 1949	NAME OF CEMETERY OR CREMATORY Bedford Cemetery	LOCATION (City, town, or county) Bedford (State) Pa.
DATE REC'D BY LOCAL REG. Oct. 10, 1949	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR John J. Hafer	ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09351

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place): 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 109 Wood St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 109 Wood St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Margaret Ellen Ryan
4. DATE OF DEATH (Month) (Day) (Year): 10 2 1949

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Nov-7-1859
9. AGE last birthday: 89 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mt. Savage, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Malloy
14. MOTHER'S MAIDEN NAME: Ellen Logsdon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Mr. Edward Ryan, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Uremia — 5 Days

450.0 Antecedent cause(s) (b) Arterio Sclerosis - Diabetes — Years

61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1945, to Oct 2, 1949, that I last saw the deceased alive on Sept 30, 1949, and that death occurred at 11:30 P.m., from the causes and on the date stated above.

SIGNATURE: W. O. McCane (Degree or title) Md — ADDRESS: Frostburg Md — DATE SIGNED: 10-3-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 10-5-1949 — NAME OF CEMETERY OR CREMATORY: St. Michael's Cem. — LOCATION (City, town, or county): Frostburg — (State): Md

DATE REC'D BY LOCAL REG.: 10-4-49 — REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR: Jacob Hafer — ADDRESS: Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 8 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09352

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 107 Balto. St.,

3. NAME OF DECEASED (Type or Print) (First) Delia (Middle) (Hollingsworth) (Last) Scott
4. DATE OF DEATH (Month) 10 (Day) 12 (Year) 1949

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed
8. DATE OF BIRTH May 5, 1871
9. AGE last birthday 78 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Winchester, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Isaac Hollingsworth
14. MOTHER'S MAIDEN NAME Alcinda Gibson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs. Harriet Sappington Scranton, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial Failure	2 days
331 Antecedent cause(s)		
830 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Vascular Accident	10 days
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 9, 1949, to Oct. 12, 1949, that I last saw the deceased alive on Oct. 12, 1949, and that death occurred at 1:45 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Arthur F. Jones M.D. 110 S. Centre St. Oct. 12, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 10/15/49
NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery
LOCATION (City, town, or county) (State) Winchester, Va.

DATE REC'D BY LOCAL REG. Oct. 14 1949
REGISTRAR'S SIGNATURE Wesley L. Frantz, M.D.
24. FUNERAL DIRECTOR ADDRESS H. Wayne George Cumberland, Md.

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09353

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; MARYLAND; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Roube 40 Inautomobile at Buick Garage

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 61 Broadway

3. NAME OF DECEASED (Type or Print): (First) Daniel (Middle) Karl (Last) Shirey

4. DATE OF DEATH: (Month) Oct. (Day) 9 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: May 18-1903

9. AGE last birthday: 46 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher at Central High School

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Greensburg Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Fred Clark Shirey

14. MOTHER'S MAIDEN NAME: Pearl Annette Patterson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 159-16-0197

17. INFORMANT: Wife) Marion Shirey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval Between Onset and Death: at once

Antecedent cause(s) Diseases or conditinns, if any, giving rise to the above cause stating the underiying cause last (b) 4201 940

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing tn the death but nnt related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. Oct. 9-1949

23. BURIAL, CREMATION REMOVAL (Specify): Removal | DATE THEREOF: 10-9-1949 | NAME OF CEMETERY OR CREMATORY: New Alexandria Cem. | LOCATION (City, town, or county) (State): New Alexandria, Pa.

DATE REC'D BY LOCAL REG. 10-9-49 | REGISTRAR'S SIGNATURE Mrs. Nancy N. Poe | 24. FUNERAL DIRECTOR: Jacob Hafer | ADDRESS: Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 14 1949
BUREAU V. S.

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH

09354

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: Allegany · STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 14 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 704 Louisiana Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. · COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): Rear-12 Decatur St.

3. NAME OF DECEASED (Type or Print): (First) Hessie (Middle) Agnes (Last) Smith

4. DATE OF DEATH: (Month) Oct. (Day) 21 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Apr. 25-1888

9. AGE last birthday: 61 yrs.

If under 1 year: Months / Days

If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife & war work

10b. KIND OF BUSINESS OR INDUSTRY: Ford Motor Co.

11. BIRTHPLACE (State or foreign country): Flintstone Creek Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Oliver Roberts

14. MOTHER'S MAIDEN NAME: Mazie Ellen Morrissey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 367-24-2899

17. INFORMANT: Mrs. Edna O'Neal

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
45'	Immediate cause	(a) Hemopericardium	5 min.
30d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Rupture of dissecting aneurysm	30 min.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H. V. Deming M.D.	Cumberland Md.	Oct. 21-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	October 23, 1949	Prospect Christian Cemetery	near Flintstone Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 23, 1949	Walter R. Hartz, M.D.	John J. Hofer	Cumberland, Md.

VS. A15A

RECEIVED
NOV 1 1949
BUREAU V. S.

09355

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) Haneke[illegible] Street

3. NAME OF DECEASED (Type or Print): (First) Ruth (Middle) Gordon (Last) Smith

4. DATE OF DEATH: (Month) Oct (Day) 15 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 9, 1910

9. AGE last birthday: 39 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Manager

10b. KIND OF BUSINESS OR INDUSTRY: Morrons Store

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Byers

14. MOTHER'S MAIDEN NAME: Margery Bogle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216 22 5 971

17. INFORMANT: William Byers Jr

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uremia — Nephritis — Interval between onset and death: 2 weeks.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) resulting from Malignant — 445
(c) Hypertension — 131a — 3 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY —
(CITY OR TOWN) (COUNTY) (STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 8/8 49, to 10/15 49, that I last saw the deceased alive on 8/14 49, and that death occurred at 8 A.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Paul Eugene Rye, M.D. ADDRESS Lonaconing Md DATE SIGNED 10/17/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Oct 17, 1949 — NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery — LOCATION (City, town, or county) Lonaconing — (State) Md

DATE REC'D BY LOCAL REG. 10-18-49 — REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR M. Eichhorn — ADDRESS Lonaconing, Md.

RECEIVED
OCT 21 1949
BUREAU V. R.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

09356

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): In auto 4 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: in automobile on way to the Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 224 Cole St.

3. NAME OF DECEASED (Type or Print): (First) Carl (Middle) G (Last) Stall

4. DATE OF DEATH: (Month) Oct. (Day) 4 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 12-17-1912

9. AGE last birthday: 36 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipefitter

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Coldwater, Ohio.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Albert Stall

14. MOTHER'S MAIDEN NAME: Ida Meyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.2

16. SOCIAL SECURITY NO.: 276-01-0266

17. INFORMANT: Wife) Anna M.F.Stall

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: about 1/2 hour.

420.1 / 940 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V.Deming M.D. — ADDRESS: H. V. Deming M. D. Cumberland Md. — DATE SIGNED: Oct.4-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Oct 7, 1949 — NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: October 6, 1949 — REGISTRAR'S SIGNATURE: Winter R. Lantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer - Cumberland Md

VS. A15A

RECEIVED
OCT 11 1949
BUREAU F. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10213

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
LENGTH OF STAY (In this place) 54 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Andrew (Middle) (Last) Staup

4. DATE OF DEATH: (Month) October (Day) 31 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 5, 1895

9. AGE last birthday: 54 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Staup

14. MOTHER'S MAIDEN NAME: Rebeccca Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1st W.War

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs George Grindle

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

155 Immediate cause (a) Malignancy of Liver & Metastases

464 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) to lungs & brain - 2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19..., to 10/31/49, that I last saw the deceased alive on 10/31, 1949, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Paul Eugene Frye, M.D. Lonaconing Md 11/3/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Nov 3, 1949 | NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery | LOCATION (City, town, or county): Lonaconing (State): Md

DATE REC'D BY LOCAL REG. 11-5-49 | REGISTRAR'S SIGNATURE: Jeannette M Boal

21. FUNERAL DIRECTOR: M. Eichhorn ADDRESS: Lonaconing, Md.

RECEIVED
NOV 29 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

09357

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (in this place): 15 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: I509 Virginia Ave

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give locatioo): 548 North Centre St.

3. NAME OF DECEASED (Type or Priot): (First) Hazel (Middle) T. (Last) Steigerwald

4. DATE OF DEATH: (Mooth) Oct (Day) 5 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. I7, I903

9. AGE last birthday: 46 yrs. | If uoder 1 year: Months | Days | If under 24 hrs.: Hours | Mio.

10a. USUAL OCCUPATION (Give kind of work done duringmost of working dife, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreigo country): Thomas W.Va.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jasper Lee Lease W.Va. dead

14. MOTHER'S MAIDEN NAME: Ida M. Troutman W.Va. living

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo, or unknown): No | (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Robert L Steigerwald 548 North Centre St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Cervix & metastasis — Interval Between Onset and Death: 18 months

171 Antecedent cause(s)

48a Diseases or cooditions, if aoy, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but oot related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1949, to October, 1949, that I last saw the deceased alive on Oct 5, 1949, and that death occurred at 2 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George M Seaman M.D. Cumberland, Md October 7, 1949

23. BURIAL, CREMATION OR REMOVAL (Specify): Burial | DATE: Oct. 8, 1949 | NAME OF CEMETERY OR CREMATORY: Fort Ashby Cem. | LOCATION (City, town, or county) (State): Fort Ashby W.Va.

DATE REC'D BY LOCAL REG.: Oct. 7, 1949 | REGISTRAR'S SIGNATURE: Winter K. Kantz, M.D.

24. FUNERAL DIRECTOR | ADDRESS: James F. Scarpelli Cumberland, Md.

RECEIVED
OCT 11 1949
BUREAU V. S.

Within corporate limits W. C. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09358

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MARYLAND
LENGTH OF STAY (in this place) 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FROSTBURG
STREET ADDRESS R.F.D#1 (If rural, give location) National

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
HARRY		STEVENS	OCT.	12	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
MALE	WHITE	MARRIED	MARCH 15, 1881	68 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist, Retired	Chinese Corp	MARYLAND	USA

13. FATHER'S NAME: GEORGE STEVENS

14. MOTHER'S MAIDEN NAME: CATHERINE HAGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
No.	214-07-4185	Memorial Hosp.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardio vascular-renal disease (Uremia)

442 Antecedent cause(s)

131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Silicosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 6-24, 1949, to 10-12, 1949, that I last saw the deceased alive on 10-12, 1949, and that death occurred at 11:45a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. C. Williams	M.D.	Cumberland	10-12-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 15, 1949	Allegany Cemetery	Frostburg, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 13, 1949	Walter L. Rantz, M.D.	M. Eichhorn	Lonaconing, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 18 1949
BUREAU V. S.

Within corporate limits: Deming

MARYLAND STATE DEPARTMENT OF HEALTH

09359

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland.
LENGTH OF STAY (in this place): 25 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 814 Stewart Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland.
STREET ADDRESS (If rural, give location): 814 Stewart Ave.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (Last) Stevenson

4. DATE OF DEATH: (Month) Oct (Day) 3 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov 23, 1866

9. AGE last birthday: 87 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John Douglas

14. MOTHER'S MAIDEN NAME: Mary Graham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Sarah Higgins, 814 Stewart Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic myocarditis	several years
Antecedent cause(s)		
443 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) arteriosclerosis & hypertention	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 10, 1948, to Oct. 3, 1949, that I last saw the deceased alive on Oct. 1, 1949, and that death occurred at 2:30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): H.V. Deming M.D. H.V. Deming M.D. | ADDRESS: Cumberland Md. | DATE SIGNED: Oct. 4-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Oct 6, 1949 | NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery | LOCATION (City, town, or county) (State): Lonaconing Md

DATE REC'D BY LOCAL REG.: October 6, 1949 | REGISTRAR'S SIGNATURE: Winston K. Frantz, M.D.

24. FUNERAL DIRECTOR | ADDRESS: John J. Hofer Cumberland Md.

RECEIVED
OCT 11 1949
BUREAU F. B.

09360

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH· COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing — LENGTH OF STAY (in this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS Detmold Street (If rural give location)

3. NAME OF DECEASED (Type or Priot)	(First) Jane	(Middle) L	(Last) Turnbull	4. DATE OF DEATH	(Month) Oct (Day) 19 (Year) 1949
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Jan 3, 1877	9. AGE last birthday 72 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Darnley	14. MOTHER'S MAIDEN NAME Catherine Mackay				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT Catherine Rogers			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) (1) Arteriosclerosis cardiovascular disease

331 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) c̄ Congestive failure

61 (2) Diabetes

(c) (3) Cerebral Hemorrhage 1½ yrs ago c̄ paralysis down left side.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1948, to 10/19, 1949, that I last saw the deceased alive on 10/19, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul Eugene Frye	M.D	Lonaconing Md	10/24/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Oct 22, 1949	NAME OF CEMETERY OR CREMATORY Laural Hill Cemetery	LOCATION (City, town, or county) Moscow (State) Md
DATE REC'D BY LOCAL REG. 10-24-49	REGISTRAR'S SIGNATURE Jeanette M Boal	24. FUNERAL DIRECTOR M. Eichhorn	ADDRESS Lonaconing, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 4 1949
BUREAU P. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09361

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH- COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 304 Decatur Street	STREET ADDRESS (If rural, give location): 304 Decatur Street

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Mary	L	Vogel	October	31	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widow	December 15 1885	63 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House	House Wife	Folks Mill, Maryland	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry McElfish	Lula Bennett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	William Vogel, 216 Decatur St, Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinomatosis	6 mos.
170 Antecedent cause(s)	(b) Carcinoma Both Breasts	2 yrs.
50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
January 1947	Advanced Carcinoma of Both Breasts	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on Oct 15 -, 1949, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
[illegible] M.D.	Cumberland Md	10-31-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	November 3 1949	St. Lukes Cemetery	Cumberland	Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 31, 1949	Wenter K. Kantz, M.D.	William H. Kight,	Cumberland, Maryland.

RECEIVED
NOV 5 1949
BUREAU V. R.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09362

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY: Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 86 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 131 Frederick St.

2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 131 Frederick St.

3. NAME OF DECEASED (Type or Print): (First) Clara (Middle) B. (Last) Walker.
4. DATE OF DEATH (Month) Oct (Day) 22 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 25 1863
9. AGE last birthday: 86 yrs. If under 1 year Months — Days — If under 24 hrs. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James B Dyche
14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service) —
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Gladys M. Herfich, Cumbd

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years

450.0 Antecedent cause(s)

97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senility,

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1949, to Oct. 22, 1949 that I last saw the deceased alive on October 15, 1949, and that death occurred at 5 15 P. m., from the causes and on the date stated above.

SIGNATURE: B. M. Schindler MD. (Degree or title) ADDRESS: 41 Greenwood Cumberland Md DATE SIGNED: Oct. 24, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: Oct 25 '49
NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.
LOCATION (City, town, or county): Cumberland (State) Md

DATE REC'D BY LOCAL REG.: Oct. 24, 1949
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc ADDRESS: Cumberland

RECEIVED
JUL 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09363

CERTIFICATE OF DEATH

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; LENGTH OF STAY (in this place) 80 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing; STREET ADDRESS (If rural give location) Charlestown Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joseph	T	Watkinson	Oct	21	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widowed	Dec 12, 1868	80 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner	Coal Mine	Maryland	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph T. Watkinson	Elizabeth Bradley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
no		Joseph T. Watkinson Jr

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arterio-sclerotic cerebral vascular

422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d (b) Disease & Arterio sclerotic cardio- 5 yrs

(c) Vascular lesions & Auricular & Ventricular fibrillation

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ....., 1948, to 10/21, 1949, that I last saw the deceased alive on 10/21, 1949, and that death occurred at 6 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Paul Eugene Frye, M.D. Lonaconing Md 10/22/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct 23, 1949	Oak Hill Cemetery	Lonaconing Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/23/49	Jannette M Boal	M. Eichhorn	Lonaconing, Md

VS. A15

NOV 4 1940
BUREAU V. S.

09364

MARYLAND STATE DEPARTMENT OF HEALTH

Dr P R Wilson

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

T

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
LENGTH OF STAY (in this place): 71 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Walnut St Extended

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
STREET ADDRESS (If rural give location): Walnut Street extended

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Joseph (Last) Welsh

4. DATE OF DEATH: (Month) October (Day) 31, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan 6, 1878

9. AGE last birthday: 71 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): artender

10b. KIND OF BUSINESS OR INDUSTRY: Liquor store

11. BIRTHPLACE (State or foreign country): Westernport, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Welsh

14. MOTHER'S MAIDEN NAME: Agnes McDade

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-05-7819

17. INFORMANT: Carl Welsh

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary Edema	2 Days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis and Myocardial Degeneration Not Specified As Rheumatic	3 Years
	(c)	

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Bronchitis (Bronchiectasis) — 3 Years

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 28, 1949, to Oct. 31, 1949, that I last saw the deceased alive on Oct. 30, 1949, and that death occurred at 2:50 d.m., from the causes and on the date stated above.

SIGNATURE: Paul R Wilson (Degree or title) MD ADDRESS: Piedmont, W.Va. DATE SIGNED: Nov. 1, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Nov 2, 1949
NAME OF CEMETERY OR CREMATORY: Philos Cemetery
LOCATION (City, town, or county) (State): Westernport, Maryland

DATE REC'D BY LOCAL REG.: Nov 2/49
REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR ADDRESS: Ellsworth S Boal, Westernport, Md.

RECEIVED
NOV 3 1949
BUREAU OF S.

Within corporate limits
Evidence for change of birth date shown on:

09365

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

FILM No. G 122 NOV 1 1949

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
LENGTH OF STAY (in this place): MARYLAND	STREET ADDRESS (If rural, give location): [illegible] St.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary	

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Elizabeth	H.	Wharton		10	19	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	MAY 2, 1867	82 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		MARYLAND	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Ashkettle	Nan Clay

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
NO	NONE	CHARLES BAST, HANCOCK, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial failure	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	3 yrs
422.2 93d	(c) Senility	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from June 15, 1949, to Oct. 19, 1949, that I last saw the deceased alive on Oct. 19, 1949, and that death occurred at 7:00 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S. Centre St.	Oct. 20 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	OCT. 22, 1949	ST. PATRICKS CEMETERY	LITTLE ORLEANS, MD.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 20, 1949	Wynter K. Mantz M.D.	CHARLES BAST, HANCOCK, MD.	

RECEIVED
OCT 25 1949
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

09366

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: In ambulance on way to Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 413 N. Center St.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) William (Last) Williams

4. DATE OF DEATH: (Month) Oct. (Day) 16 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: June-19-1876

9. AGE last birthday: 73 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Car inspector, N&W R.Ry.

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Frostburg Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Williams

14. MOTHER'S MAIDEN NAME: Rebecca Street

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 719-03-4852

17. INFORMANT: Mr. Hager & Ins. papers

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Coronary occlusion	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Coronary sclerosis	?
	(c)		

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. Oct.17-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Oct. 19, 1949
NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REG.: Oct. 19, 1949
REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.
24. FUNERAL DIRECTOR ADDRESS: Louis Stein Inc. Cumberland Md.

RECEIVED
OCT 25 1949
BUREAU V. S.

Outside of City Limits

09367

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Vale
LENGTH OF STAY (in this place) 86 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS NATIONAL HWY. RT. 40

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Vale
STREET ADDRESS (If rural, give location) NATIONAL HWY. RT. 40

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Ellen (Last) Wintermyer
4. DATE OF DEATH (Month) Oct. (Day) 27 (Year) 1949
5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow
8. DATE OF BIRTH July23-1858
9. AGE last birthday 91 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Fredrick Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John ~~Lavin~~ Lavin
14. MOTHER'S MAIDEN NAME Mary E. Baxter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY No. ------
17. INFORMANT Mrs. Earl Adams

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Coronary occlusion	at once
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(b)	Coronary sclerosis	?
	(c)	Arteriosclerosis	?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. H.V. Deming M.D. (Degree or title) ADDRESS Cumberland Md. DATE SIGNED Oct. 27-1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct 29 49
NAME OF CEMETERY OR CREMATORY St Peter & Paul's Cem
LOCATION (City, town, or county) Cumberland (State) Md
DATE REC'D BY LOCAL REG. Oct. 29, 1949
REGISTRAR'S SIGNATURE Wintes R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS " "

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09368

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
MARYLAND
LENGTH OF STAY (In this place): 49 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
STREET ADDRESS (If rural, give location): Main St.

3. NAME OF DECEASED (Type or Print): (First) Gaynell (Middle) Kirby (Last) Yetter

4. DATE OF DEATH: (Month) Oct. (Day) 6 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: May.30-1900

9. AGE last birthday: 49 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (State or foreign country): Eckhart Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William C. Kirby

14. MOTHER'S MAIDEN NAME: Mary I. Walsh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 218-24-8779

17. INFORMANT: brother) Wm.H.Kirby

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Broken neck, Fracture of a cervical vertebrae	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Fell backward, perhaps due to vertigo.	
	(c)	

900.0
186a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
(CITY OR TOWN): Eckhart (COUNTY): Allegany (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): about 12.30 Oct.6-1949- A m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Fell backward down stairs, hit head against soil pipe.

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☐, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒ *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V Deming M.D.	Cumberland Md.	Oct. 6-1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-8-49	St. Michaels Cem.	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-7-49	Mrs. Hazel K. Roe	J. R. Hurst.	Frostburg, Md.

RECEIVED
OCT 11 1949
BUREAU V. S.